

EXHIBIT 1

GIDEON, COOPER & ESSARY

A PROFESSIONAL LIMITED LIABILITY COMPANY

315 DEADERICK STREET, SUITE 1100

NASHVILLE, TENNESSEE 37238

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MATTHEW H. CLINE
matt@gideoncooper.com

July 12, 2013

Lela Hollabaugh
 BRADLEY ARANT BOULT CUMMINGS, LLP
 1600 Division Street, Suite 700
 Nashville, TN 37203

Re: *Medical Records from St. Thomas Hospital*

Dear Lela:

We have received notices of intent for potential lawsuits related to the fungal meningitis outbreak naming STOPNC and/or Howell Allen Clinic as well as St. Thomas Hospital for the following 75 individuals:

<u>Name</u>	<u>DOB</u>	<u>Name</u>	<u>DOB</u>
Alexander, John	5/53	Demps, Jerry Ray	5/56
Bequette, Ann	1/43	Eggleston, Sue	1/62
Besaw, Travis	1/32	Evans, Danny	1/64
Bland, Carolyn	1/46	Ferguson, Rosemary	1/56
Bratcher, Ben	1/78	Glatman, Ellen	1/60
Brinton, Laura	1/63	Higdon, Shirley	1/38
Brock, Denis	1/47	Hill, Joanne	1/47
Bryant, Margaret	1/38	Hurt, Glenda	1/49
Burns, Ronda	1/62	Johnson, William	1/42
Campbell, Barbara	1/54	Jordan, Dorris	1/57
Carman, Cindy	1/71	Kinsey, John	1/62
Carroll, Theresa	1/49	Kirby, Kelly	1/32
Chambers, Kathy	1/51	Kirkwood, Joshua	1/89
Coleman, Billy Joe	1/59	Knight, Betty	1/36
Davis, Thomas (Randy)	1/46	Koonce, Carol	1/39

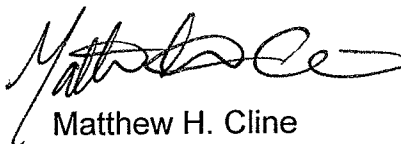
Ms. Hollabaugh
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Lankford, Charles	/37	Ruhl, Annette	/38
Lemberg, Sondra	/42	Russell, Janet	/41
Lodowski, Patricia	/45	Rybinski, Thomas	/56
Lovelace, Eddie	/34	Sawyers, John	/49
Martin, Mary	/23	Scott, Jimmy M.	/48
Mathias, Herman	/32	Settle, Harvell	/34
McCulloch, Patricia	/42	Sharer, Lewis	/36
McElwee, Basil	/39	Skelton, Reba Mae	/46
McKee, Mary	/40	Slatton, John (Jay)	/80
McKinney, Joyce	/39	Stinson, Melanie	/60
Meeker, Mary Lou	/57	Sullivan, Anna	/45
Miller, Melanie	77	Taylor, Barbara	/49
Miller, Stella	/28	Taylor, Blake	/82
Morris, Estalene	/21	Temple, Reba (2 nd request)	32
Naseef, Dorothy	/45	Turner, Rondal	63
Noble, Janet	45	Wanta, Steven R.	/56
Pellicone, Joseph	/34	Wiley, Elfrieda	/58
Pelters, Paul	45	Wilkinson, Krissy	70
Pierce, Ken (Larry)	60	Williams, Earline	40
Pruitt, Elizabeth	/39	Young, Annette	/46
Ragland, JW	41	Yuree, Edna	/34
Richards, Kevin	/67	Ziegler, Adam (2 nd request)	/80
Robnett, Reba	/46		

I have enclosed authorizations for these patients; please provide us with complete copies of their medical and billing records from St. Thomas Hospital. Also enclosed are affidavits for the custodian of records to complete and execute, certifying each set of records. Please return these to me with the records.

If you need any additional information or documentation in order to provide us with these records, please let me know. Your assistance in this matter is greatly appreciated.

Sincerely,



Matthew H. Cline

MHC/nlw
 Encls.

AUTHORIZATION FOR PRODUCTION OF MEDICAL DOCUMENTATION

Pursuant to TENNESSEE CODE ANNOTATED §29-26-122(a)(2)(E), I, John L. Alexander, Sr., have executed this HIPAA-compliant medical authorization that authorizes the Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, to obtain complete medical records regarding myself, John L. Alexander, Sr., Social Security Number -9620, and date of birth 1/1953.

The medical documentation which is authorized to be copied and produced to Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC, would include, but not be limited to, medical records, medical reports, medical charts, X-ray reports or films, diagnostic studies, psychiatric records, psychological records, pharmacy or prescription medication records, pathology reports or slides, medical billing statements, and/or other documents, writings or tangible things related to the medical care and treatment of John L. Alexander, Sr.. The medical information that is authorized to be produced includes, but is not limited to, protected health information as defined at 45 C.F.R. 164.500, *et seq.*, (The HIPAA Privacy Rule).

I, John L. Alexander, Sr., understand that the information in the health records may include information which is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

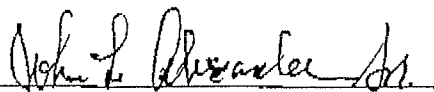
I, John L. Alexander, Sr., understand that I have the right to revoke this authorization at any time. I, John L. Alexander, Sr., understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and/or employment human resources or personnel department. I, John L. Alexander, Sr., understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, or event or condition: June 28, 2020.

I, John L. Alexander, Sr., understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I, John L. Alexander, Sr., understand that I may inspect or copy the information to be used or disclosed, as provided by CFR 164.524. I, John L. Alexander, Sr., understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I, John L. Alexander, Sr., understand that the medical documentation and health information is being disclosed due to my claims for the severe injuries which I allege were caused when I was injected with contaminated drug products while I was under the care and treatment of Saint Thomas Outpatient Neurosurgical Center, LLC. The contaminated drug products were obtained by Saint Thomas Outpatient Neurosurgical Center, LLC from New England Compounding Pharmacy, LLC.

This health information may be disclosed to and may be used by the following organization:

Saint Thomas Outpatient Neurosurgical Center, LLC, and/or the designated
legal representative for Saint Thomas Outpatient Neurosurgical Center, LLC
4230 Harding Road, Suite 901
Nashville, TN 37205
Telephone # (615) 341-3425


John L. Alexander, Sr.

Date: 6/28/13

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Ann Bequette Patient Identifier: DOB: -1943

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies; laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the individual

Expiration and Revocation of This Authorization

Expiration Date or Event: 12/18/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Ann Bequette 5/18/13
Signature (Patient) Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <u>Travis Besaw</u>	Birth Date: <u>'82</u>	Social Security No. (optional): <u>-9369</u>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. YJB (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be rediscovered.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Robert Young</u>	Date: <u>5/17/13</u>
Print Name of Patient/Plan Member's Representative: <u>Robert Young</u>	Relationship to Patient/Plan Member: <u>Attorney</u>

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Carolyn E. Bland Patient Identifier: DOB: 1-1946

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 10-3-2013

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Carolyn E. Bland 04-03-13
Signature (Patient) Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <u>Ben Batchel</u>	Birth Date: <u>178</u>	Social Security No. (optional): <u>-9540</u>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State: <u>T</u>	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. BG B (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Benjamin G. Batchel</u>	Date: <u>5-20-13</u>
Print Name of Patient/Plan Member's Representative: <u>Robert Young</u>	Relationship to Patient/Plan Member: <u>Attorney</u>

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Laura Brinton

Birth Date: 63

Social Security No.: 1-2028

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LB (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Laura Brinton

3/25/13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Laura Brinton

Self

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: 1947 Social Security Number: -7255

1. I authorize Patricia Beckham, pharmacist, John Culclaire, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclaire, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.
2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

<input type="checkbox"/> Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)	<input type="checkbox"/> Summary
<input type="checkbox"/> Copy of Medical Records only	<input type="checkbox"/> Discharge Summary (DS)
<input checked="" type="checkbox"/> Copy of Complete Records (Medical & Financial)	<input type="checkbox"/> Operative/Procedure Report(OP)
<input type="checkbox"/> History and Physical (H&P)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation	<input type="checkbox"/> Laboratory Report

 Other: _____
3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.
4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.
5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Denis S. Brock</u>	Date: <u>7-25-13</u>
Print Name of Patient/Plan Member's Representative: <u>Denis S. Brock</u>	Relationship to Patient/Plan Member: <u>Self</u>

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: Margaret Rhea BryantSocial Security Number: 1-7413Date of Birth: 1938Phone Number: 931.668.4722

1. I authorize Saint Thomas Health Services, Saint Thomas Outpatient Neurosurgical Center, LLC, St. Thomas Hospital, St. Thomas Hospitalist Group, St. Thomas Neurology Group, PLC to disclose my health information to:

Galligan & Newman, 309 W. Main Street, McMinnville, TN 37110, Christina S. Sadlow, M.D., Damon M. Abaray, M.D., E. Berry Holt, III, Gregory B. Lanford, M.D., Heritage Medical Associates, P.C., Howell Allen Clinic, John R. Voigt, Esq., Joseph R. Zenisek, M.D., Steven A. Embry, M.D., Subir Prasad, M.D., Vanderbilt University Medical Center

The purpose(s) for the use or disclose is as follows: Litigation.

2. The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from July 1, 2012 to September 18, 2012.

☐ Abstract (includes H&P, Progress Notes,
Procedure Notes, Procedure Reports, etc.)

☐ Summary

☐ Copy of Medical Records only

☐ Discharge Summary (DS)

☐ Copy of Complete Records (Medical & Financial)

☐ Operative/Procedure Report(OP)

☐ History and Physical (H&P)

☐ Pathology Report

☐ Consultation

☐ Laboratory Report

Other:

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Bertan W. Bryant
Signature of Patient or Legal Representative

Oct. 5, 2012
Date

If signed by Legal Representative, Relationship to Patient

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: Ronda Burns Social Security Number: xxx-xx-5327
 Date of Birth: -62 Phone Number: 615-452-1383

I authorize: John W. Culclasure, M.D.
Timothy Schoettle, M.D.
Saint Thomas Outpatient Neurosurgical Center, LLC
St. Thomas Hospital
Saint Thomas Health Services

to disclose my information to: Howell Allen Clinic

The purpose(s) for the use or disclose is as follows: Litigation

The type and amount of information to be used or disclosed is as follows:

Health information covering treatment from August 1, 2012 to August 1, 2013

<input type="checkbox"/> Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)	<input type="checkbox"/> Summary
<input type="checkbox"/> Copy of Medical Records only	<input type="checkbox"/> Discharge Summary (DS)
<input checked="" type="checkbox"/> Copy of Complete Records (Medical & Financial)	<input type="checkbox"/> Operative/Procedure Report(OP)
<input type="checkbox"/> History and Physical (H&P)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation	<input type="checkbox"/> Laboratory Report
Other:	

I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Ronda Burns

Signature of Patient or Legal Representative

4.16.13
Date

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: <u>Barbara Campbell</u>		Birth Date: <u>1/54</u>		Social Security No. (optional): <u>3280</u>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: <u>April 1, 2014</u> Event:					
Purpose of disclosure: <u>COMPLIANCE WITH T.C.A. § 29-26-121</u>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input checked="" type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>BC</u> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Barbara Campbell</u>				Date: <u>5/19/13</u>	
Print Name of Patient/Plan Member's Representative: <u>Barbara Campbell</u>				Relationship to Patient/Plan Member: <u>Attorney</u>	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: CINDY A. CARMAN	Birth Date: 1971	Social Security No. (optional): 2889	
Provider's/Health Plan's Name: ST. THOMAS HOSPITAL	Recipient's Name: SAINT THOMAS OUTPATIENT NEUROSURGICAL CENTER LLC Through Principal Place of Business		
Provider's/Health Plan's Address: E. Berry Holt, III Ste 800 102 Woodmont Blvd., Nashville, TN 37205-2221	Address 1: FL9		
	Address 2: 4230 HARDING PIKE		
	City: NASHVILLE	State: TN	Zip: 37205-2013

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: Event: **DISMISSAL OF LITIGATION**Purpose of Disclosure: **Legal**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description: ALL	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> ALL PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm strips		<input checked="" type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing information		<input type="checkbox"/> UB-92:	
<input type="checkbox"/> Clinical test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> ER information		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must complete Section B; otherwise, skip to Section C.

Will the recipient receive financial or in-kind compensation for using or disclosing this information? If yes, describe:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
-----------------------------------------------------------------------------------------------------------------------------	------------------------------	----------------------------------------

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Cindy A. Carman</i>	Date: x 7-2-13
Print Name of Patient/Plan Member's Representative: CINDY A. CARMAN	Relationship to Patient/ Plan Member:

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Theresa Carroll</i>	Birth Date: <i>1/49</i>	Social Security No. (optional): <i>-9568</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
 Date: *April 1, 2014* Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *TC* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Theresa Carroll</i>	Date: <i>5/19/13</i>
Print Name of Patient/Plan Member's Representative: <i>Theresa Ann Carroll Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Kathy J. Chambers

Birth Date: 05/16/51

Social Security No.: 415-88-9081

Persons or Organizations Authorized to Disclose the Information:

Howell Allen Clinic a Professional Corporation

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-12

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ☒ (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Print/Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Kathy J. Chambers

Self

AUTHORIZATION FOR "LEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations:					
Patient/Plan Member Name: <u>Billy Joe Coleman</u>		Birth Date: <u>1/59</u>		Social Security No. (optional): <u>3273</u>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: <u>April 1, 2014</u> Event:					
Purpose of disclosure: <u>COMPLIANCE WITH T.C.A. § 29-26-121</u>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>BJC</u> (Initial) If not applicable, check here: <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Billy Joe Coleman</u>				Date: <u>5/20/13</u>	
Print Name of Patient/Plan Member's Representative: <u>Robert Young</u>				Relationship to Patient/Plan Member: <u>Attorney</u>	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Thomas Randy Davis	Birth Date: , 1946	Social Security No. -2523
Provider's/Health Plan's Name: ST. THOMAS HOSPITAL	Recipient's Name: SAINT THOMAS OUTPATIENT NEUROSURGICAL CENTER, LLC Through: Principal Place of Business Address FL 9 4230 Harding Pike Nashville, TN 37205-2013	
Provider's/Health Plan's Address: E. Berry Holt, III STE 800 102 Woodmont Blvd Nashville, TN 37205-2221		

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event: DISMISSAL OF LITIGATION**Purpose of Disclosure: **Legal**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description: ALL	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> ALL PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm strips		<input checked="" type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing information		<input type="checkbox"/> UB-92:	
<input type="checkbox"/> Clinical test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication sheets		<input type="checkbox"/> ER information		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?

If yes, the health plan or health care provider must completed Section B; otherwise, skip to Section C.

Will the recipient receive financial or in-kind compensation for using or disclosing this information? ☐ Yes ☒ No

If yes, describe:

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date: **7/2-13**

Print Name of Patient/Plan Member's Representative:

Thomas Randy DavisRelationship to Patient/
Plan Member:

Apr. 16. 2013 3:42PM

No. 1885 P. 5

**AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

Patient Name: Jerry Demps Social Security Number: xxx-xx-1190
Date of Birth: -56 Phone Number: 931-510-9225

I authorize: John W. Culclasure, M.D.
Scott Standard, M.D.
Howell Allen Clinic, A Professional Corporation
St. Thomas Hospital
Saint Thomas Health Services

to disclose my information to: Saint Thomas Outpatient Neurosurgical Center, LLC

The purpose(s) for the use or disclose is as follows: Litigation

The type and amount of information to be used or disclosed is as follows:

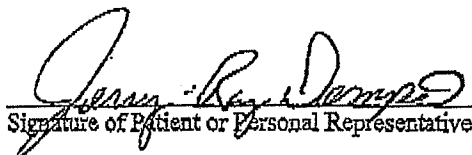
Health information covering treatment from June 1, 2012 to June 1, 2013

<input type="checkbox"/> Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)	<input type="checkbox"/> Summary
<input checked="" type="checkbox"/> Copy of Medical Records only	<input type="checkbox"/> Discharge Summary (DS)
<input checked="" type="checkbox"/> Copy of Complete Records (Medical & Financial)	<input type="checkbox"/> Operative/Procedure Report(OP)
<input type="checkbox"/> History and Physical (H&P)	<input type="checkbox"/> Pathology Report
<input type="checkbox"/> Consultation	<input type="checkbox"/> Laboratory Report
Other:	

I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to redisclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.


Signature of Patient or Personal Representative

4-15-13
Date

AUTHORIZATION FOR RECEIVE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Sue Eggleston

Birth Date: 1/62

Social Security No.: -0343

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
 Saint Thomas Network
 Saint Thomas Health
 Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. SE (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

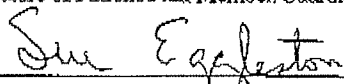
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

3-25-13

Print Name of Patient/Plan Member's Representative:

Sue Eggleston

Relationship to Patient/Plan Member:

Self

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Danny Evans	Birth Date: 1/64	Social Security No. (optional): -1823	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **April 1, 2014** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **DJE** (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Danny Evans	Date: 5/22/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Rosemary C. Ferguson		Birth Date: 1/1956		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Rosemary C. Ferguson				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Ellen Glatman		Birth Date: 1960		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

R:\ST\log\FOI\MS 78\Medical Authorization\docx

J. STEPHEN KING
JKING@EVANSPETREE.COM

DIRECT FAX 901.374.7548

February 15, 2013

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

St. Thomas Outpatient Neurosurgical Center
Debra Schamberg
4230 Harding Road, Suite 901
Nashville, TN 37205

RE: Notice of Claim for Medical Malpractice
Shirley R. Higdon
DOB: 6/1938
MRN#: SC24325

Gentlemen:

Please be advised that this office represents Shirley R. Higdon whose date of birth is 1938. Mrs. Higdon is the patient whose treatment is the subject of this notice and claim.

I am the attorney representing Shirley R. Higdon. My name and address are:

J. Stephen King
Evans | Petree PC
1000 Ridgeway Loop Road, Suite 200
Memphis, Tennessee 38120

The name and address of all healthcare providers against whom this claim is being made and to whom notice is being provided are as follows:

Name	Current Business Address	Dept. of Health website address
St. Thomas Outpatient Neurosurgical Center	4230 Harding Road, Suite 901 Nashville, TN 37205	Debra Schamberg 4230 Harding Road, Suite 901 Nashville, TN 37205
Howell Allen Clinic	2011 Murphy Avenue Suite 301 Nashville, TN 37203	

Feb. 25. 2013 8:01AM

No. 0124 P. 5

E/P

Page 2

	Attn: Gregory B. Lunford, M.D., Registered Agent	
Saint Thomas Network	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III
Saint Thomas Health	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: E. Berry Holt III	
Saint Thomas Hospital	4220 Harding Pike Nashville, TN Attn: Dawn Rudolph	102 Woodmont Blvd. Suite 800 Nashville, TN 37205 Attn: Dawn Rudolph

Enclosed is a HIPAA client medical authorization signed by Mrs. Higdon permitting you to obtain complete medical records from each healthcare provider being sent this notice.

Sincerely,


James Stephen King

JSK/lrs

Enclosure

cc: Mrs. Shirley R. Higdon

Gregory B. Lunford, M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Joanne L. Hill

Birth Date: 3/47

Social Security No.: --3908

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *JLH* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Joanne L. Hill

Date:

Apr 1, 2013

Print Name of Patient/Plan Member's Representative:

Joanne L. Hill

Relationship to Patient/Plan Member:

Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Glenda J. Hurt Patient Identifier: DOB: -1949

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.; Saint Thomas Network; Saint Thomas Health; Patricia G. Beckham

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the individual

Expiration and Revocation of This Authorization

Expiration Date or Event: 6/14/14

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Glenda J. Hurt 6/14/13
Signature (Patient) Date

Stephanie Pelley
Signature (Witness)

Signature (Authorized Representative) Date

Friend
Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Patient/Plan Member Information

Patient/Plan Member Name: William E. Johnson, Sr. Birth Date: 4/2 Social Security No.: 0664

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 26-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X EKG Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill: X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. W E J (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37203 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

William E. Johnson, Sr.

3-21-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

William E. Johnson, Sr.

Self

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Dorris Jordan		Birth Date: /1957		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY IMEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Dorris Jordan</i>				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: John Kinsey		Birth Date: /1962		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Kelly A. Kirby

Birth Date: 62

Social Security No.: -1159

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
 Saint Thomas Network
 Saint Thomas Health
 Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. KK (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

4-29-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Kelly A. Kirby

Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Joshua Luke Kirkwood Patient Identifier: DOB: 1989

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider(s):

Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic, a Professional Corporation, Saint Thomas Network Saint Thomas Health, St. Thomas Hospital, John Spooner, M.D., John Weeks Culclasure, M.D., Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., registered agent for service of process, 2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023 or Suite 901, 4230 Harding Pike, Nashville, TN 37205-2013

Purpose of the Requested Use or Disclosure

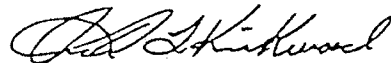
Health care liability claim.

Expiration and Revocation of This Authorization

Expiration Date or Event: Conclusion of litigation.

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.



3/12/13

Signature (Patient)

Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RECEIPT OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: **Betty L. Knight** Birth Date: **5/36** Social Security No.: **1-1585**

Persons or Organizations Authorized to Disclose the Information: **St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic**

Persons or Organizations Authorized to Receive the Information: **Saint Thomas Outpatient Neurosurgical Center, LLC**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **04/20/14** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record		<input checked="" type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input checked="" type="checkbox"/> Admission form		<input checked="" type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input checked="" type="checkbox"/> Dictation reports		<input checked="" type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input checked="" type="checkbox"/> Physician orders		<input checked="" type="checkbox"/> X Rhythm Strips		<input checked="" type="checkbox"/> Itemized bill:	
<input checked="" type="checkbox"/> Intake/outtake		<input checked="" type="checkbox"/> Nursing Information		<input checked="" type="checkbox"/> UB-92:	
<input checked="" type="checkbox"/> Clinical Test		<input checked="" type="checkbox"/> Transfer forms		<input checked="" type="checkbox"/> Other: all diagnostic	
<input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> ER Information		films, x-rays, MRIs,	
				CAT scans, etc.	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **13/K** (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel **Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205** within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Betty L. Knight

4/1/13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Betty L. Knight Betty L. Knight

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: **Carole B. Koonce** Birth Date: **/39** Social Security No.: **-9922**

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **04/20/14**

Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **CBK** (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Carole B Koonce

Date:

3/22/2013

Print Name of Patient/Plan Member's Representative:

Carole B. Koonce

Relationship to Patient/Plan Member:

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)					
Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Charles Lankford		Birth Date: 1937		Social Security No. (optional):	
Provider's/Health Plan's Name: St. Thomas Hospital		Recipient's Name:			
Provider's/Health Plan's Address: 4220 Harding Road Nashville, TN 37205		Address 1:			
		Address 2:			
		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: April 1, 2014 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input checked="" type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:				Date:	
Print Name of Patient/Plan Member's Representative: Robert Young				Relationship to Patient/Plan Member: Attorney	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Sondra R. Lemberg	Birth Date: 1/42	Social Security No.: -1607
---------------------------------------------	------------------	----------------------------

Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC
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This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. SRL (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Sondra R. Lemberg

2/12/13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Sondra R. Lemberg

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Patricia S. Lodowski	Birth Date: 1/45	Social Security No.: 1-9883
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. PSL (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Patricia S. Lodowski</u>	Date: <u>3/28/2015</u>
Print Name of Patient/Plan Member's Representative: Patricia S. Lodowski	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Eddie C. Lovelace	Birth Date: /34	Social Security No.: -4889
----------------------------------------------------	------------------------	-----------------------------------

Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, I.I.C
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This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: **04/20/14** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dietation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92; <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *JJL* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel **Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205** within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Joyce J. Lovelace</i>	Date: 03/21/2013
Print Name of Patient/Plan Member's Representative: Joyce J. Lovelace	Relationship to Patient/Plan Member: Wife

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Mary Neal Martin Patient Identifier: DOB: 1923

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

At the request of the undersigned

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/30/2013

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Signature (Patient)

Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

Patricia Martin 4/30/2013
Daughter

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Herman M. Mathias		Birth Date: 3/36		Social Security No.: 4-2243	
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic			Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC		
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>MM</i> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.					
Section B:					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Herman M. Mathias</i>				Date: 4/12/13	
Print Name of Patient/Plan Member's Representative: Herman M. Mathias				Relationship to Patient/Plan Member: Self	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Patricia C. McCulloch Birth Date: 3/42 Social Security No.: -0297

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *PC M* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Patricia C. McCulloch

3/21/13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Patricia C. McCulloch

Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Basil McElwee, Jr. Patient Identifier: DOB: 1/1939

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, laboratory data and records, pathological reports, slides and specimens, insurance records, bills or statements of account, incident reports, and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient.

THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL(S) or ORGANIZATION(S).

Persons or Organizations Authorized to Disclose the Information

Health Care Provider(s): Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic, a Professional Corporation, Saint Thomas Network, Saint Thomas Health, St. Thomas Hospital, Scott C. Standard, M.D., Rachel C. Rome, M.D., John Weeks Culclasure, M.D., Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

John Weeks Culclasure, M.D., or his representative, attorney or investigator, Howell Allen Clinic, 2011 Murphy Ave, Ste. 301, Nashville, TN 37203 or Saint Thomas Outpatient Neurosurgical Center, Suite 901 4230 Harding Pike, Nashville, TN 37205-2013

Purpose of the Requested Use or Disclosure

Healthcare liability claim.

Expiration and Revocation of This Authorization

Expiration Date or Event: Conclusion of litigation.

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Basil McElwee Jr 4/9/13
Signature (Patient) Date

Billie Kaye Hayward 4/9/13
Signature (Witness)

Signature (Authorized Representative) Date

Relationship to Patient

AUTHORIZATION FOR RECEIVE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Mary E. McKee Birth Date: 1/40 Social Security No.: -4688

Persons or Organizations Authorized to Disclose the Information: Persons or Organizations Authorized to Receive the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. Mer (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Mary E. McKee

3/25/2013

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Mary E. McKee

Self

HIPAA

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <u>Joyce P. McKinney</u>	Birth Date: <u>- 1939</u>	Social Security No. <u>- 6954</u>
Provider's/Health Plan's Name & Address: <u>See Attached</u>	Recipient's Name: <u>Dr. John W. Culclasure</u>	
	Address 1: <u>Saint Thomas Outpatient Neurosurgical Center</u>	
	Address 2: <u>4230 Harding Road, Ste. 901</u>	
	City: <u>Nashville, TN 37205</u>	State: _____ Zip: _____

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: _____ Event: Conclusion of Litigation

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. X No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record		<input checked="" type="checkbox"/> Operative Information		<input checked="" type="checkbox"/> Labor/delivery sum.	
<input checked="" type="checkbox"/> Admission form		<input checked="" type="checkbox"/> Cath lab		<input checked="" type="checkbox"/> OB nursing assess	
<input checked="" type="checkbox"/> Dictation reports		<input checked="" type="checkbox"/> Special test/therapy		<input checked="" type="checkbox"/> Postpartum flow sheet	
<input checked="" type="checkbox"/> Physician orders		<input checked="" type="checkbox"/> Rhythm Strips		<input checked="" type="checkbox"/> Itemized bill:	
<input checked="" type="checkbox"/> Intake/outtake		<input checked="" type="checkbox"/> Nursing Information		<input checked="" type="checkbox"/> UB-92:	
<input checked="" type="checkbox"/> Clinical Test		<input checked="" type="checkbox"/> Transfer forms		<input checked="" type="checkbox"/> Other: all diagnostic	
<input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> ER Information		films, x-rays, MRIs,	
				CAT scans, etc.	
				<input checked="" type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by the above named recipient for which I am granting my authorization.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above named recipient shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel William D. Vines, III, Butler, Vines & Babb, PLLC, 2701 Kingston Pike, Knoxville, TN 37919, within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated:

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Joyce P. McKinney</u>	Date: <u>6-12-13</u>
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Mary L. Meeker	Birth Date: 1/57	Social Security No.: -9595
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Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC
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This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. MM (Initial) If not applicable, check here. ☐

I understand that:

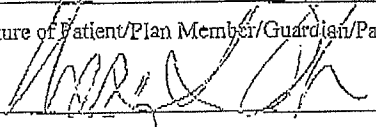
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 	Date: 4-12-2013
Print Name of Patient/Plan Member's Representative: Mary L. Meeker	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.					
Patient/Plan Member Name: <i>Melanie Miller</i>		Birth Date: <i>1/77</i>		Social Security No. (optional): <i>7-2284</i>	
Provider's/Health Plan's Name:		Recipient's Name:			
Provider's/Health Plan's Address:		Address 1:			
		Address 2:			
		City:	State:	Zip:	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: <i>April 1, 2014</i> Event:					
Purpose of disclosure: <i>COMPLIANCE WITH T.C.A. § 29-26-121</i>					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input checked="" type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <i>[Signature]</i> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it.					
Section B:					
The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Melanie Miller</i>				Date: <i>5/23/13</i>	
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>				Relationship to Patient/Plan Member: <i>Attorney</i>	

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Stella M. Miller Birth Date: 4/28 Social Security No.: 0296

Persons or Organizations Authorized to Disclose the Information: Persons or Organizations Authorized to Receive the Information:

St. Thomas Hospital
 Saint Thomas Network
 Saint Thomas Health
 Saint Thomas Medical Clinic

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *S.M.* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Stella M. Miller

3-22-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Stella M. Miller

Self

UNIVERSITY MICROFILMS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: <u>Dorothy Nasref</u>	Birth Date: <u>1/45</u>	Social Security No. (optional): <u>-9 088</u>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record		<input checked="" type="checkbox"/> Operative information		<input checked="" type="checkbox"/> Labor/delivery info.	
<input checked="" type="checkbox"/> Admission forms		<input checked="" type="checkbox"/> Cath lab		<input checked="" type="checkbox"/> OB nursing notes	
<input checked="" type="checkbox"/> Dictation reports		<input checked="" type="checkbox"/> Special test/therapy		<input checked="" type="checkbox"/> Postpartum doc sheet	
<input checked="" type="checkbox"/> Physician orders		<input checked="" type="checkbox"/> Rhythm Strips		<input checked="" type="checkbox"/> Combined bill	
<input checked="" type="checkbox"/> Intake/outtake		<input checked="" type="checkbox"/> Nursing Information		<input checked="" type="checkbox"/> UB-92:	
<input checked="" type="checkbox"/> Clinical Test		<input checked="" type="checkbox"/> Transfer forms		<input checked="" type="checkbox"/> Other all diagnostic	
<input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> films, x-rays, M&Is,	
				<input checked="" type="checkbox"/> CAT scans, etc.	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. IN (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any action taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by the office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office under Bates number and copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the release of this authorization.

Section C: Signature

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Dorothy Nasref</u>	Date: <u>5/20/13</u>
Print Name of Patient/Plan Member's Representative: <u>Robert Yurum</u>	Relationship to Patient/Plan Member: <u>Attorney</u>

Revised 3/2003

C - 4

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Janet M. Noble Birth Date: 45 Social Security No.: 6419

Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *JMN* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Janet M. Noble</i>	Date: <i>March 27, 2013</i>
Print Name of Patient/Plan Member's Representative: Janet M. Noble	Relationship to Patient/Plan Member: Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Joseph M. Pellicone Patient Identifier: DOB: 1934

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic A Professional Corporation or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 9/27/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Joseph M. Pellicone 3/27/13
Signature (Patient) Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Paul H. Pelters

Birth Date:

45

Social Security No.:

5028

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
 Saint Thomas Network
 Saint Thomas Health
 Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. PHR (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

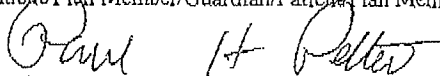
Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:



Date:

3-15-13

Print Name of Patient/Plan Member's Representative:

Paul H. Pelters

Relationship to Patient/Plan Member:

Self

STATE OF TEXAS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations:

Patient/Plan Member Name: <u>Ken Pierce</u>	Birth Date: <u>60</u>	Social Security No. (optional): <u>1-3398</u>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
 Date: April 1, 2014 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. B (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>[Signature]</u>	Date: <u>5/23/13</u>
Print Name of Patient/Plan Member's Representative: <u>Larry E. (Ken) Pierce Jr. Robert Wang</u>	Relationship to Patient/Plan Member: <u>Attorney</u>

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Elizabeth A. Pruitt Birth Date: 59 Social Security No.: 5519

Persons or Organizations Authorized to Disclose the Information: Persons or Organizations Authorized to Receive the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill; <input checked="" type="checkbox"/> UB-92; <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LES (Initial) If not applicable, check here, ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE, 127 Woodmont Boulevard, Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Leslie C. Shadowhawk

3-21-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Leslie C. Shadowhawk

Daughter

May. 6. 2013 9:10AM

No. 1920 P. 20

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: J.W. Ragland	Birth Date: /41	Social Security No.: ' 8512
----------------------------------------	-----------------	-----------------------------

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. BR (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:



3-22-2013

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Becky Ragland

Wife

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Kevin R. Richards Patient Identifier: DOB: 1967

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

At the request of the individual

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/21/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

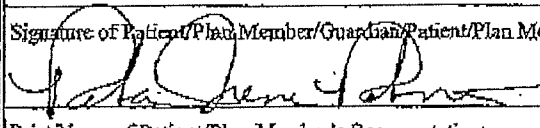
Kevin R. Richards 4/21/13
Signature (Patient) Date

McLyn Richards
Signature (Witness)

Signature (Authorized Representative) Date

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations					
Patient/Plan Member Name: Reba June Robnett		Birth Date: /46		Social Security No.: -1817	
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic			Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC		
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need:					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
X All PHI in medical record X Admission form X Dictation reports X Physician orders X Intake/outtake X Clinical Test X Medication Sheets		X Operative Information X Cath lab X Special test/therapy X Rhythm Strips X Nursing Information X Transfer forms X ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet X Itemized bill X UB-92: X Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>RL</u> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.					
Section B:					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signature					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: 				Date: 3-22-13	
Print Name of Patient/Plan Member's Representative: Reba June Robnett				Relationship to Patient/Plan Member: Self	

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Annette S. Ruhl Birth Date: /38 Social Security No.: 951

Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92; <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. ASR (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Annette S. Ruhl

3-21-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Annette S. Ruhl

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Janet M. Russell	Birth Date: /41	Social Security No.: - /629
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Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. mmc (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Janet M. Russell

4-12-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Janet M. Russell

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorization.

Patient/Plan Member Name: Thomas W. Rybinski	Birth Date: /56	Social Security No.: -8466
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Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC
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This authorization will expire on the following: (Fill in the Date or the Event but not both.)
 Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. SCR (Initial) If not applicable, check here. ☐

- I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
 5. I understand that I my attorney will receive copies of all records received through this authorization.
 6. I, through my attorney, will get a copy of this form after I sign it.
 7. A photostatic copy of this Authorization is to be considered as effective as the original.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signature

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Silva Colette Rybinski	Date: 3/20/13
Print Name of Patient/Plan Member's Representative: Colette Rybinski	Relationship to Patient/Plan Member: Wife

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION
PURSUANT TO HIPAA C.F.R. 164.512**

I authorize the use/disclosure of health information as described below.

1. Person(s) or class of persons, medical provider or other entity or person authorized to disclose the information: _____
2. Person(s) or class of persons or provider, company or entity to whom the information may be disclosed: ST. THOMAS OUTPATIENT NEUROSURGICAL CENTER, LLC
3. I understand that this may include information relating to acquired immunodeficiency syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), psychiatric care, treatment for alcohol and/or drug abuse, and/or genetic testing.
4. Description of information to be disclosed: Medical records and reports, patient information and history forms, x-rays, x-ray report, pathology, pathology reports, insurance records, health care providers' reports and consultations, prescriptions, off-work slips, therapy records, lab reports, notes, tests and billing records and statements.
5. The information will be used/disclosed for the following purposes: For medical providers and any other person or entity to obtain medical records for the purpose of determining what happened to John Charles Sawyers and what persons, manufacturers, distributors, purchasers or entities are responsible for causing injury to Mr. Sawyers and for any other lawful purpose.
6. I understand that the health information described above may be redisclosed and no longer protected by federal and state privacy regulations.
7. I understand that my healthcare or payment for healthcare will not be affected if I refuse to sign this authorization.
8. In consideration of the release of information by _____, in accordance with this request, I hereby release _____, its agents, servants, and employees from any and all claims, demands, or liability of any kind, which might arise of or from the release of such information and the effects thereof.

I understand that I have the right to revoke this authorization in writing at any time by sending written notice of revocation to the person(s), class of persons or provider, company or entity at the above address. I understand my revocation of this authorization will not be effective as to uses and/or disclosures of any information that the person(s) and/or organization have previously provided. A copy of this signed release shall be deemed as effective as if it were the original.

This authorization shall expire two years from the date of its execution.

John Charles Sawyers
JOHN CHARLES SAWYERS

DOB: /1949
S.S. NO: -3457

John Charles Sawyers

DATE: 6-10-13

May. 10. 2013 9:45AM

No. 1931 P. 10

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Jimmy M. Scott	Birth Date: 1/48	Social Security No.: -6887
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Persons or Organizations Authorized to Disclose the Information:	Persons or Organizations Authorized to Receive the Information:
------------------------------------------------------------------	-----------------------------------------------------------------

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JSK (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Jimmy M. Scott

3-23-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Jimmy M. Scott

JIMMY M SCOTT

Self

Mar. 26. 2013 11:26AM

No. 1860 P. 5

**Authorization for Release of Medical Records and
Protected Health Information**

TO:

I, **Harold Sellers**, in compliance with the newly instituted requirements of HIPAA, hereby authorize and request **Saint Thomas Outpatient Neurosurgical Center, LLC, Saint Thomas Network, Saint Thomas Health, St. Thomas Hospital, and Howell Allen Clinic A Professional Organization** to release or disclose to bearer, or permit bearer to view, and/or to furnish bearer with copies of all billing and medical records or other information pertaining to drug prescriptions, hospitalizations, and/or outpatient care related to the treatment of **Harold Sellers**.

I further authorize you to photocopy and mail all documents, records, laboratory results, prescription records, or other medical information to:

**Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023**

This authorization will expire one year from the date it was signed, unless revoked sooner. I understand that I may revoke this authorization in writing at any time, to the extent that disclosure has not already occurred prior to my request for revocation. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that treatment or payment cannot be conditioned on my signing this authorization.

This information will be used for legal investigation purposes. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule.

I agree that a photocopy of this authorization be accepted with the same authority as the original.

Dated: 3-18-13Signed: Harold SellersPrinted: **Harold Sellers**

DOB: _____

May. 10. 2013 9:48AM

No. 1931 P. 19

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorization.					
Patient/Plan Member Name: Harvell A. Settle		Birth Date: /34		Social Security No.: -4862	
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC			
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:					
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> BR Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>HAS</u> (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I my attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.					
Section B					
THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.					
Section C: Signature					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Harvell A. Settle</u>				Date: <u>2-24-12</u>	
Print Name of Patient/Plan Member's Representative: Harvell A. Settle				Relationship to Patient/Plan Member: Self	

May. 10. 2013 9:52AM

No. 1931 P. 29

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Lewis R. Sharer	Birth Date: /36	Social Security No.: -6008
-------------------------------------------	-----------------	----------------------------

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. LS (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Lewis R. Sharer

Date:

3/20/2013

Print Name of Patient/Plan Member's Representative:

Lewis R. Sharer LEWIS R. SHARER

Relationship to Patient/Plan Member:

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Reba M. Skelton Birth Date: 1/46 Social Security No.: 9734

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
 Saint Thomas Network
 Saint Thomas Health
 Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. RS (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Reba M. Skelton

3-29-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

Reba M. Skelton

Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all authorizations.

Patient/Plan Member Name: John Jay Slatton Birth Date: /80 Social Security No.: 5212

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. JJS (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

3-21-13

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

John Jay Slatton

Self

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>McLaine Stinson</i>	Birth Date: <i>1/6/60</i>	Social Security No. (optional): <i>-1882</i>	
Provider's/Health Plan's Name:	Recipient's Name:		
Provider's/Health Plan's Address:	Address 1:		
	Address 2:		
	City:	State:	Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: *April 1, 2014* Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *MS* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>McLaine Stinson</i>	Date: <i>5/17/13</i>
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Anna M. Sullivan Birth Date: 4/45 Social Security No.: 8928

Persons or Organizations Authorized to Disclose the Information:

St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information:

Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: 04/20/14

Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. AMS (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Anna M. Sullivan

Date:

3-22-13

Print Name of Patient/Plan Member's Representative:

Anna M. Sullivan

Relationship to Patient/Plan Member:

Self

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name Barbara A. Taylor

Date of Birth -1949

Social Security Number .9448

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure: all medical sources, healthcare providers and treaters.

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> physician/nurse assessment	<input type="checkbox"/> medication list	<input type="checkbox"/> history and physical
<input type="checkbox"/> discharge summary	<input type="checkbox"/> laboratory results	<input type="checkbox"/> x-ray and imaging\ reports
<input type="checkbox"/> consultation reports	<input checked="" type="checkbox"/> entire record	<input type="checkbox"/> patient information sheet
<input type="checkbox"/> other: _____		

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization: all medical sources, healthcare providers and treaters, and their representatives,

for the purpose of litigation and to comply with Tenn. Code Ann. § 29-26-121.
6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department and requesting party. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year. I further authorize the above referenced provider to accept a copy of this Authorization instead of the original of this document, said copy to have full force and effect as though it were the original.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Barbara A. Taylor
Signature of Patient or Legal Representative

6-20-13
Date

If Signed by Legal Representative, Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: Blake Taylor	Birth Date: 1/82	Social Security No. (optional): -0293
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State:
	Zip:	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **April 1, 2014** Event:

Purpose of disclosure: **COMPLIANCE WITH T.C.A. § 29-26-121**

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☒ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. **BT** (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Blake Taylor	Date: 5/23/13
Print Name of Patient/Plan Member's Representative: Robert Young	Relationship to Patient/Plan Member: Attorney

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Rondal Turner</i>	Birth Date: <i>1/6/63</i>	Social Security No. (optional): <i>1107</i>
Provider's/Health Plan's Name:	Recipient's Name:	
Provider's/Health Plan's Address:	Address 1:	
	Address 2:	
	City:	State: Zip:

This authorization will expire on the following. (Fill in the Date or the Event but not both.)
Date: *April 1, 2014* Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record		<input checked="" type="checkbox"/> Operative Information		<input checked="" type="checkbox"/> Labor/delivery sum.	
<input checked="" type="checkbox"/> Admission form		<input checked="" type="checkbox"/> Cath lab		<input checked="" type="checkbox"/> OB nursing assess	
<input checked="" type="checkbox"/> Dictation reports		<input checked="" type="checkbox"/> Special test/therapy		<input checked="" type="checkbox"/> Postpartum flow sheet	
<input checked="" type="checkbox"/> Physician orders		<input checked="" type="checkbox"/> Rhythm Strips		<input checked="" type="checkbox"/> Itemized bill	
<input checked="" type="checkbox"/> Intake/outtake		<input checked="" type="checkbox"/> Nursing Information		<input checked="" type="checkbox"/> US-92:	
<input checked="" type="checkbox"/> Clinical Test		<input checked="" type="checkbox"/> Transfer forms		<input checked="" type="checkbox"/> Other: all diagnostic	
<input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> ER Information		films, x-rays, MRIs,	
				CAT scans, etc.	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *PT* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <i>Robert Young</i>	Date: <i>5/23/13</i>
Print Name of Patient/Plan Member's Representative: <i>Robert Young</i>	Relationship to Patient/Plan Member: <i>Attorney</i>

Revised 3/2003

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations.

Patient/Plan Member Name: Steven R. Wanta Birth Date: 7/56 Social Security No.: 2770

Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital
Saint Thomas Network
Saint Thomas Health
Saint Thomas Medical Clinic

Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92; <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. SW (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: Steven R. Wanta Date: 3-20-13

Print Name of Patient/Plan Member's Representative: Steven R. Wanta Relationship to Patient/Plan Member: Self

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: **Elfrieda H. Wiley** Patient Identifier: DOB: /1958

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Health Care Provider(s): **Persons Or Organizations Authorized To Disclose The Information**

Saint Thomas Outpatient Neurosurgical Center, LLC, Howell Allen Clinic, a Professional Corporation, Saint Thomas Network Saint Thomas Health, St. Thomas Hospital, Timothy P. Schoettle, M.D., John Weeks Culclasure, M.D., Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Howell Allen Clinic, a Professional Corporation, or any representative, attorney or investigator from said organization c/o Gregory B. Lanford, M.D., registered agent for service of process, 2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023

Purpose of the Requested Use or Disclosure

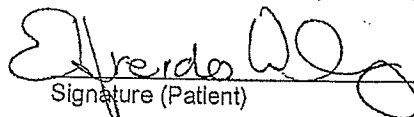
Healthcare liability claim.

Expiration and Revocation of This Authorization

Expiration Date or Event: Conclusion of litigation

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

 05/01/2013
Signature (Patient) Date

Signature (Authorized Representative) Date

Signature (Witness)

Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed for all Authorizations

Patient/Plan Member Name: <i>Kristy Wilkinson</i>	Birth Date: <i>1/70</i>	Social Security No. (optional): <i>1213</i>
------------------------------------------------------	----------------------------	------------------------------------------------

Provider's/Health Plan's Name:	Recipient's Name:
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Provider's/Health Plan's Address:

Address 1:

Address 2:

City:

State:

Zip:

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: *April 1, 2014*

Event:

Purpose of disclosure: *COMPLIANCE WITH T.C.A. § 29-26-121*

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☒ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outtake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input checked="" type="checkbox"/> Labor/delivery sum. <input checked="" type="checkbox"/> OB nursing assess <input checked="" type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. *W* (Initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.

Section B:

The purpose of the release of my records is for review by [medical care provider] for which I am granting my authorization. **THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH ANY [MEDICAL CARE PROVIDER OR THEIR REPRESENTATIVES] OUTSIDE THE PRESENCE OF MY ATTORNEYS.** You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by [medical care provider] shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel [attorney and address], within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:

Date:

Print Name of Patient/Plan Member's Representative:

Relationship to Patient/Plan Member:

LIMITED AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OR RECORDS

By signing below, I hereby request and authorize the Health Care Provider identified below to disclose certain information (the "Information") as provided in this Authorization.

Information To Be Used Or Disclosed

Patient Name: Earline T. Williams Patient Identifier: DOB: 1940

Description of Information: Any and all medical information and records, or true and correct copies thereof, in your possession, custody or control, including, but not limited to, medical histories, records, reports, summaries, diagnosis, prognoses, records of treatment and medication ordered and/or given, entries, letters or correspondence to other physicians, electrocardiograms, x-ray films and reports, ultrasounds, diagnostic imaging studies, laboratory data and records, pathological reports, slides and specimens, prescription records, Insurance records, bills or statements of account, incident reports, birth certificates, death certificates and all other written or graphic data prepared, kept, made or maintained in your possession, custody or control and summaries of injuries, treatment and prognosis, if requested, that pertain to the Patient. THIS AUTHORIZATION DOES NOT AUTHORIZE VERBAL COMMUNICATIONS WITH THE REFERENCED INDIVIDUAL OR ORGANIZATION.

Persons Or Organizations Authorized To Disclose The Information

Health Care Provider: Saint Thomas Outpatient Neurosurgical Center, LLC; Howell Allen Clinic A Professional Corporation; St. Thomas Hospital; John Weeks Culclasure, M.D.; Debra V. Schamberg, R.N.

I authorize the Health Care Provider(s) and its employees and agents to disclose the Information as provided in this Authorization. A photostatic copy of this Authorization is to be considered as effective as the original. I understand that I am not required to sign this Authorization. The Health Care Provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Persons or Organizations Authorized to Receive the Information

Saint Thomas Outpatient Neurosurgical Center, LLC or any representative, attorney or Investigator from said organization, c/o Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste 301, Nashville, TN 37203-2023 or Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013.

Purpose of the Requested Use or Disclosure

Legal

Expiration and Revocation of This Authorization

Expiration Date or Event: 10/11/13

I understand that I may revoke this Authorization at any time prior to the expiration date or event, but that my revocation will not have any affect on actions taken by the Health Care Provider, its employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the Health Care Provider at the following address:

I understand that I may see and copy the Information if I ask for it. I understand that any Information released may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy law or regulations.

Signature (Patient) _____ Date _____

Maureen W. Williams 4/11/13
Signature (Authorized Representative) Date

Signature (Witness) _____

SON
Relationship to Patient

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: This section must be completed in full. Authorizations

Patient/Plan Member Name: Annette G. Young	Birth Date: 1/45	Social Security No: -6457
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic	Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: 04/20/14 Event:

Purpose of disclosure: COMPLIANCE WITH T.C.A. § 29-26-121

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission form <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/buillake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill: <input checked="" type="checkbox"/> UB-92: <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. My (initial) If not applicable, check here. ☐

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that my attorney will receive copies of all records received through this authorization.
6. I, through my attorney, will get a copy of this form after I sign it.
7. A photostatic copy of this Authorization is to be considered as effective as the original.

Section B:

THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a date-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard, Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Annette G. Young</u>	Date: <u>3-21-13</u>
Print Name of Patient/Plan Member's Representative: Annette G. Young	Relationship to Patient/Plan Member: Self

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient/Plan Member Name: Edna Younce		Birth Date: 30	Social Security No.: 1440
Persons or Organizations Authorized to Disclose the Information: St. Thomas Hospital Saint Thomas Network Saint Thomas Health Saint Thomas Medical Clinic		Persons or Organizations Authorized to Receive the Information: Saint Thomas Outpatient Neurosurgical Center, LLC	
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: 04/20/14 Event:			
Purpose of disclosure: COMPLIANCE WITH T.C.A. § 26-26-121			
Description of information to be used or disclosed			
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.			
Description:	Date(s):	Description:	Date(s):
<input checked="" type="checkbox"/> All PHI in medical record <input checked="" type="checkbox"/> Admission forms <input checked="" type="checkbox"/> Dictation reports <input checked="" type="checkbox"/> Physician orders <input checked="" type="checkbox"/> Intake/outake <input checked="" type="checkbox"/> Clinical Test <input checked="" type="checkbox"/> Medication Sheets		<input checked="" type="checkbox"/> Operative Information <input checked="" type="checkbox"/> Cath lab <input checked="" type="checkbox"/> Special test/therapy <input checked="" type="checkbox"/> Rhythm Strips <input checked="" type="checkbox"/> Nursing Information <input checked="" type="checkbox"/> Transfer forms <input checked="" type="checkbox"/> ER Information	
		<input type="checkbox"/> Labor/delivery som. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input checked="" type="checkbox"/> Itemized bill <input checked="" type="checkbox"/> UB-92 <input checked="" type="checkbox"/> Other: all diagnostic films, x-rays, MRIs, CAT scans, etc. <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. <u>Eda</u> (Initial) If not applicable, check here. <input type="checkbox"/>			
I understand that: 1. I may refuse to sign this authorization and that it is strictly voluntary. 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise. 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices. 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed. 5. I understand that I may attorney will receive copies of all records received through this authorization. 6. I, through my attorney, will get a copy of this form after I sign it. 7. A photostatic copy of this Authorization is to be considered as effective as the original.			
<p>THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE ABOVE-LISTED ENTITIES OR THEIR REPRESENTATIVES OUTSIDE THE PRESENCE OF MY ATTORNEYS. You may furnish this law firm records that are requested by this office. All medical records obtained pursuant to this authorization by the above-listed entities shall be copied by their office and a Bates-numbered copy shall be furnished to my counsel Randall L. Kinnard; KINNARD, CLAYTON & BEVERIDGE; 127 Woodmont Boulevard; Nashville, TN 37205 within five (5) days after the records are obtained through the use of this authorization.</p>			
I have read the above and authorize the disclosure of the protected health information as stated.			
Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative: <u>Edna Younce</u>		Date: <u>3-26-2013</u>	
Print Name of Patient/Plan Member's Representative: <u>Edna Younce</u>		Relationship to Patient/Plan Member: <u>Self</u>	

Mar. 26. 2013 11:27AM

No. 1860 P. 9

**Authorization for Release of Medical Records and
Protected Health Information**

TO:

I, Adam Ziegler, in compliance with the newly instituted requirements of HIPAA, hereby authorize and request Saint Thomas Outpatient Neurosurgical Center, LLC, Saint Thomas Network, Saint Thomas Health, St. Thomas Hospital, and Howell Allen Clinic A Professional Organization to release or disclose to bearer, or permit bearer to view, and/or to furnish bearer with copies of all billing and medical records or other information pertaining to drug prescriptions, hospitalizations, and/or outpatient care related to the treatment of Adam Ziegler.

I further authorize you to photocopy and mail all documents, records, laboratory results, prescription records, or other medical information to:

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford M.D.
2011 Murphy Avenue
Suite 301
Nashville, TN 37203-2023

This authorization will expire one year from the date it was signed, unless revoked sooner. I understand that I may revoke this authorization in writing at any time, to the extent that disclosure has not already occurred prior to my request for revocation. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that treatment or payment cannot be conditioned on my signing this authorization.

This information will be used for legal investigation purposes. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the rule.

I agree that a photocopy of this authorization be accepted with the same authority as the original.

Dated: 19 MARCH 2013

Signed: Adam C. Ziegler

Printed: Adam Ziegler

DOB: -1980